

**HIT Policy Committee  
Certification/Adoption Workgroup  
Transcript  
February 21, 2014**

**Presentation**

**Operator**

All lines are bridged.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Certification/Adoption Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Larry Wolf?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Larry. Marc Probst?

**Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Marc. Carl Dvorak? Donald Rucker?

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Donald. Liz Johnson? George Hripcsak? Jennie Harvell?

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Jennie. Joan Ash? John Derr?

**John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, John. Joe Heyman? Larry Wolf; I'm sorry, I already called you. Marty Rice? Maureen Boyle?

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration**

I'm here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Micky Tripathi? Mike Lardieri? Paul Egerman?

**Paul Egerman – Businessman/Software Entrepreneur**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Paul. Paul Tang?

**Michael Lardieri, LCSW, MSW – Vice President, Health Information Technology & Strategic Development – National Council for Behavioral Health**

Hi, Mike Lardieri joined.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Mike Lardieri. Stan Huff? And from ONC, do we have Liz Palena-Hall?

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Yup, here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Liz. Elise Anthony?

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator for Health Information Technology**

Here Michelle.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Elise. And Jennifer Frazier.

**Jennifer Frazier, MPH – Policy Analyst – Department of Health & Human Services**

Here.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Jennifer. And with that, I'll turn it back to you Larry.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, well, welcome back everybody. We're heading – we're turning the corner; maybe we can even see the end in sight here. Today's plan is finish up the behavioral health specific discussion, based on the hearing. Then step back a little bit and look more broadly at what we're doing, what are our overriding principles and after some slides about those principles, then we'll start diving in to more of the substance of what certification criteria we should be recommending. So that's the plan. This is the first of two wrap-up calls, so hopefully we can finish up the behavioral health pretty quickly and spend the bulk of our time today sort of on the framework of how we're going to be responding and beginning to look at the specifics of the certification criteria and the recommendations. Any other comments? Marc, anything else you want to say for intro.

**Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare**

No, let's go.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, let's do it.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

This is Carl; I joined too, by the way, just a little bit late.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Hi, Carl. So I think we're okay on the schedule, a reminder that we have a meeting on 3/6 that's going to be talking about Standard Occupational Classification codes and some other work that the sub-workgroup of this workgroup has been doing on workforce development. It's a little bit of a break from the certification stuff we've been doing. And then again, both of these things will be presented to the Policy Committee at the March meeting and they'll be an update to Standards as well at the end of March and then we're expecting another round of respond to what the Policy Committee has to tell us and final updates going at the beginning of April. So you should be actually getting an invitation to some meetings, I know ONC has been circulating some possible times for meetings in April, to respond to the – late March and early April to respond to the feedback we're going to get. Next slide.

Okay, so let's wrap up behavioral health. Next slide. So can we keep our standard going here? The ONC folks talk about what we heard and then the workgroup will talk about where we're going.

**Jennifer Frazier, MPH – Policy Analyst – Department of Health & Human Services**

Okay, sounds good. So during the hearing we heard the need for patient assessments, which would be behavioral health setting specific criterion, this was supported by panelists stating that there are currently different code sets and assessments that are required for behavioral health. They said that current challenges with comparative data elements, that there are an average number of data elements collected during the intake process – intake to treatment planning process ranges from 1715 to 2100 data elements. And they also went on to say that in one state alone that there are 18,000 different diagnostic assessment form styles and versions that were in use. We heard from another panelist that states have different requirements for collecting and reporting standardized elements for behavioral health.

And so our proposed areas for certification would be to support the ability to create, maintain and transmit in accordance with federal and state requirements, assessment instruments and data sets for behavioral health. And for future work, we would expand upon the existing standards to develop certification criteria for this purpose.

**Paul Egerman – Businessman/Software Entrepreneur**

This is Paul Egerman; can I ask a question about these standards that are in the middle bar?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Go.

**Paul Egerman – Businessman/Software Entrepreneur**

To what extent – what is their status, are they used? Are the operational? How frequently are they used? Who do you send these assessments to? Can you tell us a little bit more about these?

**Jennifer Frazier, MPH – Policy Analyst – Department of Health & Human Services**

Maureen, are you –

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration**

Yes, this is Maureen from SAMHSA. I actually don't really know the answer to that. Do we have anybody on who does?

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

This is Jennie and in terms of the first standard that is referenced, the CDA Patient Assessment, Release 1, that was balloted, I'm trying to remember if it was last year or the year before. And I am trying to recall anybody who's actually using that standard to support the exchange of their assessment instruments.

**Paul Egerman – Businessman/Software Entrepreneur**

And the second one? I mean it says Version 3, so – suggests that somebody must be using it if you got to Version 3.

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration**

Yeah, I mean I believe that, and I can send an email quickly and see if I can get an answer to send out to people. I believe that Arizona is using it, but I'm – because they're part of the CBC, the workgroup that's been – the HL7 Workgroup that's been working on this, but I'll see if I can get an answer to that.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

I thi –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So –

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine**

Are Version 2 and Version 3 referring to the broader HL7 standards, I think, as opposed to a specific behavioral health?

**Paul Egerman – Businessman/Software Entrepreneur**

That's a good observation, because they both say Release 1. So –

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine**

I mean, yeah, because – yeah, I mean as a very general – I'm sure Carl can speak to this more specifically, Version 2 is pretty widely used as general, not behavioral health per se, but a lot of the Version 3 stuff is really work in progress.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah and they both say Release 1 on them, and what – my point is, you've got some standards that maybe have even balloted and maybe one organization is using it somewhere, to me that's not enough for certification on a national basis. You run the significant risk of certifying something that either nobody uses or, worse than that, if they try to use it, it has – it creates some workflow challenges, it creates some problems. Just to standardize this by itself, just seems like there's no –

**M**

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

– I don't see where the benefit is, I can see some risks.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

I agree with you Paul, these standards – I don't know for certain, my impression from having dealt with them through the years is that as these pop up, they're often extraordinarily immature and although someone has standard in progress, these are not standards that everybody has implemented. So I think if we're going to require them for certification, we should understand the prevalence of implementation across the vendor community that is intended to be certified. Or you're just going to get a mad scramble to try to implement something that may not even be well enough defined, and may not have gone through enough vetting to be truly useful. I would definitely do a survey on actual real implementations of these with a count of live interfaces across the community that these certification standards would impact.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

This is Larry; let me jump in with kind of an observation, compare and contrast. So the similar discussion on the LTPAC side talked about their regulatory assessments, which have an existing format technology for transmittal to the government, have been in place for a while, and there's been some work done to convert those into CDA documents, in addition to their standard format. And I think that work is actually pretty well established. On the behavioral health side, my understanding, and I think we heard this at the hearing, is that there is a huge range of assessment tools and the forms for those. And the comments that were included here about the large number of those existing in one state analysis I think speaks to behavioral health being more immature in this.

And the question, I guess, that we're being asked, it might actually be a question to bounce to the standards guys when we hand this over to them, is what you've been talking about. Is these, as I remember right, these HL7 – the HL7 assessment – the PDA for assessments, and I think Jennie's right, I think it was at least a year ago that that went through ballot, was meant to be a general container to hold assessments. And so the question is, as a general container, is it sufficiently both robust and simple enough that it would be a good recommendation to say, use this container to package up your assessments but the actual assessments themselves, I think, are still in flux.

The part that I think is interesting in the proposal here is, it's actually pulling out some very focused things, a functional assessment scale, patient placement criteria, as opposed to the more broader discussion of assessments in general. So I wonder if others on the workgroup have thoughts about sort of the two-part here, that the standards are really a general toolkit for using – for packaging up assessments and that the particular recommendations here are pointing to some standards that might be available for some of the vocabulary, some of the sections within those documents.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine**

Well I would say then we would probably need to – and it's Don – probably have a specific link to that subsection.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

I don't know, maybe – I mean, I haven't clicked through on these links to see where they go, but it should be more specifically identified than I think it is here.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Paul Egerman – Businessman/Software Entrepreneur**

And my comment is, as I'm looking at this, I'm just confused. I certainly see the expression Release 1 on both of these and that's like a red flag to me. But if sort of like....implementation guide or something, there's a whole series of things where you're like defining – there are data definitions and data elements, that sort of...and it would seem to me that would be potentially very useful, straighten out what I suspect is sort of part of the mess with all these different assessments.

I think one of the things that ONC could do that would be particularly useful would be to sort of say, now here's the code set; here are the data definitions everybody needs to be working with. But I don't know that I see that in this – what's written here. What I'm worried about is what's written here is just a way to transmit these assessments back and forth and that it's an information exchange standard that is immature and I'm not sure – if that's the case, it doesn't accomplish anything, but if it –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So –

**Paul Egerman – Businessman/Software Entrepreneur**

– defines the data elements, then it does accomplish something.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So to respond, Paul, to that, the top one, the top standards to support is the Consolidated CDA implementation guide, so Release 2, I believe is referring to that part.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Actually –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

New in that was the patient assessment as one of the document types.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Actually, Larry, I think it is not part of the Consolidated CDA. Sue Mitchell is on the phone and she can correct me if I'm wrong, but some years ago, there was an earlier version of this HL7 standard, CDA that supported both the transmission of assessments as well as identifying content standards to be included for assessment information. And this Release 2 is an update of that earlier standard, still using the Consolidated CDA, excuse me, not the Consolidated CDA, still using CDA and incorporating vocabulary standards, LOINC, SNOMED and other vocabularies to support the representation of assessment content.

**Paul Egerman – Businessman/Software Entrepreneur**

Let me ask a question. Would it be stronger for ONC rather than do this, it somehow called out what you called the content, that vocabulary, LOINC, the data code sets. And ONC said these – this is the data structures that we want the country to standardize on so that people can gather the same kind of data and be talking in effect, the same language with each other. It would seem to me that would be a very useful thing for ONC to be doing; it just bothers me that to the extent of doing it, it's sort of buried in here.

**Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare**

This is Stan Huff. I – yeah, I mean, just in terms of what this statement means, I mean there is CDA and there was CDA Release 1 and then there was CDA Release 2 and the top standard that they're referring to is an additional implementation guide on top of CDA Release 2 that's specifically about patient assessment. And the – what's implied there is exactly as described, I mean, the patient assessments themselves, the actual content if you will, would be represented by a combination of LOINC codes and SNOMED codes and other value sets.

And I think where the disconnect comes in is then you go over to the other side where – to the right-hand column, the proposed BH certification, and it talks about ASAM and PPC and what I don't know is whether – my guess is that those instruments today are being used as paper documents. And whether or not those particular instruments have been encoded in LOINC and SNOMED is something I just don't know factually, whether those things are available. And I don't know to what extent anyone is using them electronically and so I worry that it's premature to require them for certification when I'm – I don't know at least, of anyone who's using those instruments electronically.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes. And so that's very helpful Stan. I mean, do you think I'm on the right track by saying that ONC would add value simply by spotlighting the content standards and the code set and say this is what we want the country to be using.

**Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare**

Yes, I think that would be a useful recommendation.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah. I mean, my two cents is in general, when ONC does that, it moves us all forward, we're all on to LOINC now, we're all on to SNOMED now, we can forget about some of the other arguments about which one to choose. And I just, it seems that that part of the standardization process has a huge amount of value.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine**

The second link in the standards that support this, Version 3, that document is really an analysis framework, not an actual standard, at least if you look at the top-level Web page. So that should probably be removed or a more specific link to begin with, because it's a background for analysis rather than a standard, just clicking on the link.

**Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare**

Yeah, you're right, I think it's really, if you will, a reference document that, well it provides what it says, it's domain analysis, but there's no – I don't know how you would assess whether someone was compliant to that domain analysis model. So –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah, so the jump on that we all seem to be following the link, it says this should be used to develop specs.

**Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare**

Yeah.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I guess what I'm hearing is, the two specific references given here are new to us collectively and they might be known to the Standards guys, but they are new to us. And given that, we're suggesting that they may not be in widespread use and if there's counter-information that would be helpful. But also that in general we think that getting the data defined, getting the vocabulary clear, where we've got specialized assessments, like we do in behavioral health, that that would be a very good step forward and becomes a building block. And then those code sets actually could be used in lots of contexts.

**Paul Egerman – Businessman/Software Entrepreneur**

That's right, and that that data definition, I don't know if that's certification criteria, but it would just be, as you said, useful in lots of contexts in behavioral health.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah. Well, I was looking at –

**Paul Egerman – Businessman/Software Entrepreneur**

Like the government –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– some of the material from the –

**Paul Egerman – Businessman/Software Entrepreneur**

– says use meters versus –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– 2014 Rule.

**Paul Egerman – Businessman/Software Entrepreneur**

Pardon me?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I think we've got some echo here. By looking at some of the certification documentation that came out 2-3 years ago as the 2014 edition was being made public and it began with the word standards, standards in certification criteria. So I think if we look broadly at what ONC puts forward as part of their editions, it is naming of standards.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Well there are two things here, right, there's a standard within which you can create other standards, so it's a standard for creating templates within which you can standardize templates, more or less. And I think as long as we remember that there are two elements here, we're okay. The standard within which you can define the standard templates is acceptable and appropriate, but templates that would need to be defined aren't probably as mature or even as available as needed yet. Stan, would you agree?

**Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare**

Yeah, I think that's exactly accurate. I mean CDA 2 is well accepted, well understood. The particular implementation guide – and particularly implementation guides that would have behavioral health content, I think we're early in that adoption and understanding.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

One – so, I appreciate this conversation. I have a question, I think, for Maureen. These various assessments, Maureen, that are used in the behavioral health space, do you know anything about their use? And specifically, I know in long-term post-acute care there's electronic transmission of these ass – of different assessment documents, is that the case also in the behavioral health arena?

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration**

So my understanding within the behavioral health arena is that there are not really federal standards around most of these assessments, so most of these are kind of state-based requirements. There definitely is some electronic submission, but it's not very prevalent. And I agree with the discussion that's gone on, I think kind of standardizing the way that this information is captured and transmitted, like standardizing the code sets, makes a lot of sense to me.

**Michael Lardieri, LCSW, MSW – Vice President, Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yeah, this is Mike and yeah, I agree with Maureen. There's no federal standard and it really depends on what state or what county you're working in, decides to use what. Like over on the right-hand column you'll see the ASAM patient placement criteria, many organizations use that, some states require you to use that, not all states. And when you get to assessments, there are all kinds of other assessments that are not standardized state-based assessments, for instance, assessments for anxiety disorder, assessments for developmental disorders, assessments for Alzheimer's and there are a whole slew of psychological assessments that you would use as well. PHQ2, or PHQ9 actually, would be another example.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

So I was trying to get a sense of, I understand and agree with the importance of identifying standards to be used for content. I'm wondering if there is value in behavioral health for identifying a standard document template for assessments.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

There probably is, but that's work that you need to do – well certainly and in Medicare, so if you have a Medicare patient, there's a certain set of standards that you need to do there for your psychiatric history, your social history, those kinds of things. Many Medicaid states, under Medicaid, they mirror that, some add additional pieces. So if there was one federal standard that would help. I think what folks are looking for from behavioral health is that when you have an open-source standard, you're able to put in the description of the answer and the answer and so you can actually see that and then track it over time. And if it's a proprietary type of assessment, well then, you don't want to have to pay for it, so you're just going to be able to track the response or the sum score, but still be able to use that assessment and track it over time. That's really what people were getting to over on the right-hand column.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So let me see if we can get some closure on this, based on what I heard from Stan and Paul, mostly. So and I guess Carl. So, I'm hearing we have two pieces here, we have a CDA document type around surveys, around assessments, which is outside the regular Consolidated CDA, so I take back my earlier statement, thanks you guys for getting me to click through. And as industry guys, you don't know about whether that particular document type has gotten much traction. I suspect if you haven't heard of it, probably not, but it's worth seeing if we actually have any survey information about its use.

And so there's question about what's the right container for surveys, but there also is the vocabulary that's being used and where there are existing standards to build on, that that would be a thing for ONC to point to, and would enable sort of doing the foundational work as some of the container stuff continues to evolve. So am I hearing right that there might be a two-part recommendation here, one is, there is a container out there that might be appropriate, but we don't know, get some information about it. And there are some existing vocabulary standards and having clarification about which standards to focus on is helpful to the industry, so ONC should do that.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes, vocabulary standards and data definitions.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Agree. And by the way, I apologize, I have to drop off the phone for a short while, but I'll rejoin probably in 15.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay.

**Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare** Yeah, I think that's a good approach also. This is Stan.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

This is Jennie, I agree.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Great, so let's move on guys.

**Jennifer Frazier, MPH – Policy Analyst – Department of Health & Human Services**

Okay, for vital signs we had somewhat conflicting views on this. One panel stated that one of the Meaningful Use functions least relevant to psychiatry were vital signs. But in contrast, we heard that there was support for the requirement to capture vital signs by behavioral health organizations because many are focusing on integrated care due to co-occurring physical health issues and that being able to share data between behavioral health and physical health IT systems would drive positive clinical outcomes. So our proposed areas for behavioral health certification would be to support the ability to electronically record, change and access, at a minimum, a patient's height, weight, length and blood pressure and automatically calculate and display the BMI.

**Paul Egerman – Businessman/Software Entrepreneur**

So, this is Paul. My comment here is, I'm assuming that we're looking at ineligible providers. And it just strikes me that social workers, psychologists aren't going to be taking vital signs. I suspect the ones who do take vital signs are eligible providers or eligible providers who practice in some multispecialty environment. I'm a little bit surprised by this really, because it relates to the ineligible.

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration**

So this is Maureen from SAMHSA. I agree with that entirely and I think this kind of goes back to that modular versus – or however, I can't even remember the terms that we said that we were going to use, but the modular versus core, even though ignore those terms. Like, if we were to do something that's applicable across all ineligible behavioral health providers, I would not include this. But I think having a vital signs module or vital signs included in a module could be useful, if we're trying to make a more flexible program.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

And this is –

**Paul Egerman – Businessman/Software Entrepreneur**

My comment –

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

– Mike. The other thing that you have is because you have so many part-time psychiatrists and part-time nurse practitioners who if they were full-time they'd be eligible, when they're part-time, they're ineligible because they're spread out all over the place. And it would apply to some of them, as ineligible.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So you're saying – so, Mike, this is a nuance here. You're saying that there might be a psychiatrist working in a behavioral health context and because they're part-time there, that time it isn't sort of rolled into their eligibility requirement and so they're below the threshold, whatever it is, for minimum Medicare –

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yeah, they're part-time in too many places so they never really make it to get a full load to be eligible any place.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So you're saying that this might be useful in that system and the fact that they're a type of provider who could be eligible, in specific they're not.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

That's correct. Yeah.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And so again, this might go to buying decision of the organization that if based on the providers they have, they might want to have a module that does vital signs.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Exactly. Yup.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

It's not cor – it's not within the sweet spot, I'll make some new language up here, it's not within the sweet spot for behavioral health.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yeah, that's correct. Exactly what you're saying is what I meant, uh huh.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So maybe this is a place where we say, there are a lot of things in the certification criteria that could be of use in a particular setting, and so we don't want to say don't do them. But we're also not going to specifically highlight them, and maybe this is an example for behavioral health where not highlighting it is the relevant thing.

**Paul Egerman – Businessman/Software Entrepreneur**

I mean, that's right, I mean basically, I don't know if I'm looking at this right. But the way I'm looking at it, is a purchaser could choose any number of modules that are important to them and that we don't necessarily have to identify this as a module, to get them to decide if that's important for them to have.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right, it would be part of the regular module set.

**Paul Egerman – Businessman/Software Entrepreneur**

Because it is already part of the regular module set.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

But it seems it's minimally useful for a non-eligible. I mean, it may be the case that Mike refers to, it's not useful across the board.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah, I think this is a good place where, in contrast to many of the LTPAC settings are institutional settings where there's nursing staff of various levels that routinely take vital signs. And they would say no, vital signs is part of what we do, so different in behavioral health. So my sense is we're saying that while what's here is accurate, in terms of the proposal, that we're not actually proposing this for behavioral health, right? Our sense is that here's an existing module, providers can use it as appropriate, but it's not a primary piece for behavioral health.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

And it's Don, another challenge here that we want to maybe at some point think about is, as we potentially put things into modules, figuring out which modules what would go into –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

– and this one strikes me, as I'm thinking about, where would you put vital signs, that's not clear to me. I mean I could imagine a couple of different places.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah, so, hold on to that thought because we're going to need to think about that as we look more broadly at our recommendations, about what are the useful groupings. What we're going to see in the subsequent slides are some pretty big lumpings and you guys might have thoughts about, do we want more granular or don't want more granular. So how do we get closure on this? I think we're all – everyone who's talking seems to be saying, we might have a provider who wants to do vital signs, there's an existing module to do it, might or might not be part of what the vendor certified.

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration**

This is Maureen, I totally agree with that.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

So Larry, by saying that though, you're saying it would not be required, correct?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Well, Liz, none of this is required, but yes, I guess I'm saying is, I want to move it out of the sweet spot, I want to move it out –

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Right. Okay.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– we're going wind up saying, some things, we just think these are important, do it. Other things might make sense in the setting –

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Other things are part of – and they're specific to the setting and don't exist in the current criteria. Other things exist in the current criteria and we have a sense of, these are important to these settings or these are less important. And in my mind, this is in the less important.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Okay, just checking, that's – I agree.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

That's what I'm trying to say.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Got it.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And we need to figure out how to say that. That will be part of how we make our recommendations piece broadly.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Right. Thank you. Yup.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Larry, we had a conversation kind of like this during the last call –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

– and so I would imagine if you were an institutional provider, this might be important to you and if you're not, then it might not be important at all or maybe less important.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

So, yeah, I think we'll need the wording on that, because even in the behavioral space, there are institutional providers.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

That's a good reminder, I forgot about the psych hospitals in my earlier comment.

**Paul Eggerman – Businessman/Software Entrepreneur**

But the psych hospitals are not eligible hospitals.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Correct, they're not eligible.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Not as yet.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yup, there were three major classes, small but major classes of hospitals excluded from HITECH, psych, rehab and long-term acute-care. Okay, let's go on to the next one.

**Jennifer Frazier, MPH – Policy Analyst – Department of Health & Human Services**

Okay, advanced care planning. We heard that there are psychiatric advanced directives that are in place, but these differ from medical advanced directives. Psychiatric advanced directives allow a patient to document their preferences in the event they become incapable or involuntarily committed. They allow patients to indicate preferences for what types of confinement or treatment they do or do not want and they also allow the patient to appoint a representative who can make mental health care decisions for that patient. Our proposed areas for certification would be to indicate that advanced directives exist for the patient and support the ability to store an advanced directive document in the record or provide a link to their advanced directive in a repository or other location. And this is proposed currently from Meaningful Use Stage 3, so we propose that it would also be included in behavioral health if it went forward.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And so you're reference in the center column is to the 2014 edition, right?

**Jennifer Frazier, MPH – Policy Analyst – Department of Health & Human Services**

Yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Which is just, is there documentation and the next edition asks for potentially maintaining a pointer or the document itself, is that right?

**Jennifer Frazier, MPH – Policy Analyst – Department of Health & Human Services**

That's correct.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

It's Don, I guess I have two questions in looking at this. One is the sort of the medical advanced directives which I believe actually include psychiatry, right, because that would be a medical treatment I believe, are wrapped in state laws in every state. And I sort of know this because I actually signed mine at my lawyer's office this morning, not the psych one, the regular one. And so I just wonder if there's any collision with the state law. The other question is, is there any sort of standard place where people would keep this that has a URL? Because I think sort of implicit in this is that folks would have a URL to this, but I think most of these things are kept as paper documents. So, I'm not sure about the mechanics of this either.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Sure, this – Stan, this is Larry, let me jump in with – so, we had a hearing on advanced care planning, I don't know, sometime last fall. And the – there's a movement among the states, mostly under the banner of POLST, Physician Orders for Life Sustaining Treatment, that has created multistate coalition which pretty much covers I'd say three-quarters of the country, the states are doing something around standardizing what happens in their state in partnership with the other states. And at least a handful of states have set up electronic repositories with the intention that you can embed a link to that repository and get the most recent document for that individual, as well as download copies if you want to have the actual document. And ways for individuals to either directly using the site fill in the documents or to upload documents to the site.

So there is the beginnings of this out there, I think three or four states are far enough along you could say it's beyond the pilot, they actually have thous – tens of thousands, maybe hundreds of thousands of documents already under control. But it's relatively new and it's not every state yet, but many states are heading in this direction.

**Paul Egerman – Businessman/Software Entrepreneur**

So, this is Paul. In the Meaningful Use Workgroup and in other workgroups, this has been discussed and it's hard for me to know what's going to happen to it, I can't predict that of course, but the argument against it – the arguments against it are that there's actually a lot of momentum already going on around advanced directives, that's one argument. And the second argument is, it's not necessary for absolutely every single provider to have a copy of the advanced directives in their record and that could be counter-productive as it relates to various versions. Because the way this is written is that the EHR system has to be able to keep a copy of the record or alternatively a link – a link, so it does mean that absolutely every provider, every social worker, every psychologist would have a copy. And that seems a bit odd. My suggestion here is probably just a suggestion that we do whatever happens in MU3.

**John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**

This is John Derr and we're discussing this also in the Patient Engagement Workgroup and I just agree with what was just said, because we had a lot of people working on this and just say for behavioral health it will adhere to whatever Meaningful Use 3 says.

**Paul Egerman – Businessman/Software Entrepreneur**

I'm sorry, I misunderstood what you said, John, do you say you agree or you disagree?

**John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**

No, I agreed with you. I agree with you because we're working the same thing. In fact, I just gave a talk at the Oklahoma HIE yesterday and there was a guy talking about MyDirectives, which was kind of a unique way of looking at the advanced directive and that. So there are a lot of people working on that, as you said, so let's just –

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, and that's one of the reasons – and it's one of the reasons why I'm reluctant – I personally hesitant about including it in MU3 because I'm afraid we're going to get in the way of people doing good work, but that's just one opinion. I think to simply say, we'll do whatever MU3 comes out with would be a reasonable approach here.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah, I think –

**John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**

And I agree.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– I think this is an example of there are existing certification criteria that would be of value to some providers in these spaces and we want to acknowledge that, and whatever work is done should be aligned with that work. And I think it's fine if we specifically reference this as something that this should be aligned with whatever ONC does for Meaningful Use 3.

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration**

This is Maureen, I agree with that.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, let's go on. Yeah, we're now done with behavioral health as a specific drill-down. Thank you everybody. Let's go on to the next one. Okay, so we're now heading into – so now switch gears everybody. So this is the beginning of the summary, what do we want to be presenting back to the Policy Committee as what we've learned from the hearings and our discussions and becomes the framing for our recommendations and then the specific recommendations to follow. So, I put these driving factors out there as sort of a summary, we had our five factor thing, maybe I need a different word than factors in the title for this. But we were sort of saying, why, why is this important, right, and we're seeing drivers in payment models where providers are being strongly encouraged to coordinate care, so moving into the next box. Coordinate care, engage in performance improvement, all as part of participating in broad local efforts to coordinate care, improve outcomes, manage costs, it goes under bundled payment banners, it goes under avoiding readmissions, it goes under patient-centered medical home.

Those three things all work together and are driving health IT adoption and in many ways, are also picking up consumer engagement piece of – these become part of the way in which consumers get engaged in their care. That there are either documents that get handed to them or shared decision making where they and their providers are looking at a screen together or it could be some of the more remote tools that we're seeing with patient portals.

**Paul Egerman – Businessman/Software Entrepreneur**

And so Larry, you said these are the drivers of HIT adoption, which I would agree.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

But the title says driving factors for certification –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

– and certification is not the same thing as HIT adoption by...

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

That's correct.

**Paul Egerman – Businessman/Software Entrepreneur**

– any means. And so I'm confused as to how these are the drivers for certification.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So that's probably a really good point and maybe – in fact maybe in fact it would be – it would achieve what I was hoping this would achieve, is actually to say, adoption, that these are driving HIT adoption.

**Paul Egerman – Businessman/Software Entrepreneur**

They're driving HIT adoption, but there's this belief that certification will somehow improve adoption and there's no reason for me to believe that to be the case.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Well this is Jennie and I think retitling the slide, driving factors for long-term post-acute care and behavioral health adoption, I would agree that those elements on the PowerPoint are driving health IT adoption. However, at least in the long-term post-acute care space, generally speaking, the IT adoption that is being seen does not support interoperable health information exchange and does not enable the reuse of data, both of which, the exchange and the ability to reuse data I think are fundamental, I would hope, to certification criteria.

**Paul Egerman – Businessman/Software Entrepreneur**

Right and I – what you say makes sense to me, but it's almost like I would have – I look at these five slides, I don't get coordinated care as being a driving factor for certification, because that's where you get the information exchange and da – definition of data elements and of all that kind of good stuff. But the other things by themselves are not drivers of certification, they're drivers of adoption.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I think that's a really good piece and maybe this should be staged, lay out the broader context for driving adoption and then a second one that talks about driving certification.

**Paul Egerman – Businessman/Software Entrepreneur**

Right, because there's no payment model that drives for certification right now, other than the Meaningful Use Program, but we're talking about the non-eligibles, so for the non-eligibles there are no payment models, there's no HIT funding and even consumer engagement, I don't think that's a driver for certification.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right. No, I agree, it's about adoption, this slide is mistitled and I think that the adoption piece is – was the intention for here and I was being a little bit overly reflexive in not wanting to put Meaningful Use up on this slide at all, because that's not itself a driver here. It's a secondary thing, it's the bigger things really, it's the payment models.

**Paul Egerman – Businessman/Software Entrepreneur**

And in performance improvement, if we look at this as adoption, is that related to just clinical performance improvement or does that include like administrative savings and efficiencies? That would also be, in my mind, one reason one would be looking for adoption one is from the administrative savings that you get or hopefully get.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I think maybe –

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

This is Mike, I would agree with that, absolutely.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So maybe we should add a box for administrative efficiencies.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, because again, I didn't know what performance improvement meant, it could be very broad, right?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah.

**Paul Egerman – Businessman/Software Entrepreneur**

So it could include that, but usually I think people think of that in terms of like readmission rates –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Clinical –

**Paul Egerman – Businessman/Software Entrepreneur**

– and quality and things like that.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yup. So I want to respond though to the funding piece, and the reason it says HIT funding as available. While I don't expect that we're going to see any major funding into this, we have heard instances of individual grants that either say, I want you to have HIT or I'm going to pay you to acquire HIT. And the grantees are saying – the grantors are saying, I want to know that the technology they're getting meets some minimal capabilities. In the same way that the early certification activities of CCHIT were part of Stark Exceptions, that there are some reasons why certification would be useful, even without the kind of breadth and depth of funding that HITECH was.

**Paul Egerman – Businessman/Software Entrepreneur**

Well, so it's sort of like – to sort of summarize this, it seems like there are 5 things or 6 things adding the administrative savings, and those are driving factors for adoption. But the driving factors for certification are coordinated care and HIT funding as available.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right, yup. And I think we've had some discussion about value of certification and maybe we can frame up a couple of bullet points to go with that as well, as we drill into the things that certification does or doesn't do, right? Try to clarify the – it's not a broad seal of approval, it's very focused on particular functions. Any other comments about this?

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

This is Carl, I rejoined, just FYI.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay. Well good timing, Carl, just talked about the summary slide that's on the screen, did you catch the part about switching the heading here to adoption from certification?

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Yup, I was on for a couple of minutes, just waiting for a pause.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Great. And so let me make a note to myself that we're going to have a separate one for driving certification, which is care coordination and the value of care coordination – certification of care coordination is around standards for interoperability and HIT funding where available. Okay, let's go on to the next slide.

So let's see if this has also got the right headings. This was meant to be some high level principles that we were going to then apply as we go through all the detail. So we've been slugging through the detail over the last several weeks and we tried to pull out I and some of the ONC folks, tried to pull out some of the major themes that we've been hearing. So hopefully we can walk through these, sharpen these up, and get them with sufficient focus and clarity. So the very first one, we've been struggling with what the verb ought to be here, build on, harmonize, and align. The important concept was that this is taking the existing certification, reusing pieces as appropriate and in very limited ways addressing potential additions.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Yeah, I don't like that word harmonize because it sounds like there are things that would need to be harmonized and in fact I think the idea is to align and leverage existing certification criteria as much as possible when needed and then extend, if – in limited ways where necessary.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Jennie, this is Mike. The only reason I like the harmonize is because we're still in the middle of working on some of the behavioral health data sets that still need to be harmonized with the other data sets. I guess once we're there, then I would agree with you, but we still need to do that work, because there are behavioral health data sets that are not included in say the C-CDA yet, that we're still working.

**John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**

This is John Derr. I like the word align because it's more in tune with transitions.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

And I could go with that.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So do we want to pull on the notion of reuse here or maybe some of the more tech guys, I'm thinking or our vendor reps, if you've got thoughts or Stan, if you've got thoughts about how to describe this kind of reuse in a way that's sort of focused would be clear.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

I don't know the –

**Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare** The interoperability bullet sort of does pretty much hint at that and even almost says it, I guess you could label that reuse across organizations as opposed to use.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Or simply make use of existing certification program where practical.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Something a little bit more yeomen.

**Michael Lardieri, LCSW, MSW – Vice President, Health Information Technology & Strategic Development – National Council for Behavioral Health**

And is there any way you could put the interoperability first? I mean, I think that's the most important component, but – that's all, it's not required.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, so I was trying to address how this relates to certification, but I'm happy – if you think – if you guys think that sort of the value here is let's lead with the most important and put interoperability up top, I wanted to focus on the structure with those first three, sort of the structure of the program.

**Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare** Larry, I think we want to be really clear that we don't want another certification program, so leveraging the existing program's pretty important.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yeah, I'm good, I'm not having any problem with it, we'll go.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Maybe we should think about then using the word leverage, put leverage existing certification program.

**Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare**

Yeah, I think leverage is a good word because it says you're going to use – it sort of says in one word that you're going to use what applies, it doesn't mean that you have to use it all or that you can't do something in addition to either. So, but it says you're going –

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yeah, I agree with that that comment on leverage completely. I think it absolutely is the right connotation that we want.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay.

**Michael Lardieri, LCSW, MSW – Vice President, Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yes, that's good.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Next thought, ready to move on to the next thought; voluntary and modular. Right, that's been a consistent theme – not the next slide, sorry, back us up; next bullet, voluntary and modular.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah, and this is Paul. My comment is the entire certification program is voluntary –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

– and so, this is voluntary and modular and non-funded.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So the bottom bullet is even stronger than minimum burden, right.

**Paul Egerman – Businessman/Software Entrepreneur**

Well, there's no incentive program –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

– and so, I don't know if you want to put that here, but that's a critical thing people have to keep in mind, there is no incentive program around this certification, it's voluntary and modular and no federal incentives.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yeah, I think saying no incentives is the right approach, so it's crystal clear.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, I'm going to throw the word broad in there, no broad incentives, so I think my federal guys would be arguing, well but we have this program and we have that program, but they're not broad, they're not broad like Meaningful Use was broad and the HITECH funding was broad. They're very focused, limited funding.

**Paul Egerman – Businessman/Software Entrepreneur**

There are no national incentives, whatever.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah.

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Yup.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine**

I understand some of the thinking around combining voluntary and modular in one line, but I'm wondering –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

(Indiscernible)

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

– whether they're stronger if they're on separate lines because –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine**

– while there's a joint concept of modules individually or voluntary, do we want to sort of say the overall structure should be modular or there's a global thing. Because certainly if you look at, let's see, going back even to CCHIT days, they were both sort of global and modular components that sort of almost had separate lives and existences.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I'm happy having them be separate bullets. I think they're – I agree, I think they're stronger that way. Next one, focus on all provider criteria, so, let's talk about this. In the existing program with the EHs and EPs, some of the criteria are setting spec – or specific to one provider group or the other, but many of them are consistent for both. And the notion here was that where we were picking and choosing things, we were saying the high value is where there are pieces that apply to everybody, and those are pieces that need to be built on as well. And so it's continuing the notion of leveraging, but adding this notion that some criteria do apply to the intersection of all of the provider types.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Is the implication that – then that those criteria that are not applicable across all providers are not addressed?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

No. So the int – so I guess there's a stylistic question to ask you guys. So the next three bullets are all, if you will, sub-bullets of that focus on "all provider." Would that be helpful actually to indent them and make them really be sub-bullets?

**Paul Egerman – Businessman/Software Entrepreneur**

Well –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Or is it irrelevant. And again, one of the thoughts was not to make interoperability any less prominent than it is, it needs to be really –

**Paul Egerman – Businessman/Software Entrepreneur**

My concern here is the confidentiality one. I'm sure – I'm not sure I would use the word confidentiality.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Paul Egerman – Businessman/Software Entrepreneur**

I mean, it's really privacy and security. I also don't know why you would necessarily promote consent, because that's – one vehicle that is being used for privacy. So it's really privacy and security, but that's – I don't understand what that has to do with all provider criteria.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So if you look at the certification criteria, the privacy and security criteria, ones that would apply to all providers.

**Paul Egerman – Businessman/Software Entrepreneur**

Oh, I see. Wait a minute, I get a little flustered sometimes when we start to wordsmith things, but to me, if we're wordsmithing it, I would just call that privacy and security, I would not call it confidentiality – consent privacy and security, I'd just call the whole thing privacy and security because that's just how we relate to it every place else.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

And Larry, this is Liz. I just wanted to jump in with a time check, because I think we might have some guests.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, good point. It's just after noon and ONC was trying to line up some folks to talk to us about quality measures, is that right?

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Yup.

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Yes, and it's Helen Burstin, I'm the Co-Chair of the Quality Measures Workgroup and I am on, so whenever you would like, feel free. But if you want to finish up your conversation, go ahead.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, I guess what I'd like to do is get through this slide –

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Sure, please.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– and then have you join us, and we'll recognize that – we'll get through this slide and we'll get it done by – in the next 10 minutes, so that we –

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Not a problem.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– can give you some time.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

So Larry, I have a question. The bullet that says use of all provider functions within settings –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

– can you explain that bullet please?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Sure. So demographics, I'll pick one that's maybe all provider or not, and the argument might be around exactly what's in the demographics certification criteria as a module. But that would be an example of something that all providers could use. Interoperability is something that all providers could use. Privacy and security is something that all providers would use. There are some things we haven't said are at a high level for us, but if you did them, you would want them to be done using the national standards, so, there's a – I guess it's an optional one in this round, in the 2014, of doing a bulk export of information into CDA documents, under data portability. So that would be something if you did it, it would be an all provider function that was the thinking. If the word "all provider" is adding confusion here, maybe we should pull that, maybe the very fact that we're going to leverage existing programs and we're going to be modular is plenty and all the stuff around "all provider" I was getting carried away with a structure that's irrelevant.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Well I think if you – it's probably helpful, I guess, when presenting this to other groups. So if I understand your structure, you're anticipating criteria that will apply to all providers.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

And then there will be some setting specific criteria. And so I think probably, if that's – if I'm understanding you correctly, I think having that framework probably would be helpful. In terms of, I'm not sure who was speaking last on this use of the confidentiality concept, I agree that it seems more privacy and security than confidentiality.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, so I'm hearing some edits here that say, it would be clearer if the bullet that talks about all providers disappeared, we kept interoperability. We turned confidentiality, consent, privacy, security into what everybody knows it as, which is privacy and security.

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration**

So this is Maureen. I would disagree with that one slightly, just because I think current privacy and security doesn't really address the confidentiality regulations.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration**

Even if it's in parentheses or something, if we can include that word in there, I think that would be useful.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, so to your point, I think it's actually important and maybe this needs to be its own piece here. So we kept privacy and security and that rolls into the existing criteria. What we heard about, the additional consent and control issues related to SAMHSA stuff, but not necessarily only SAMHSA. Some providers talk about it as the highly confidential material, which is meant to be a broad label for a bunch of things that I believe that we've come to a conclusion that says, if you're going to be sending that and if you're going to leverage the new HL7 standards for doing that, that that affects everybody. If that was only done by the SAMHSA folks, it would be of little value because I'd be transmitting a document that says, this is confidential, you can't redistribute, and the receiving system wouldn't know how to interpret those codes, right? So, it wouldn't be useful by itself, it has to be broadly applicable.

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration**

We agree.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So what I'm thinking is, drop this back to privacy and security, but either on this slide or in the one that talks about the enhanced privacy and security related to the SAMHSA stuff in the 20 – CFR stuff, I'm blanking on numbers today, 24, 42, hike –

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

42 CFR Part 2.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– 42, thank you, pick that up separately. Drop the use of all provider functions within settings, because again, we're hitting that with modular and leverage. Setting-specific needs, I think is in fact what we're going to be talking about. Alignment across federal and state programs, so, I think this is actually a key thing that we're hearing in this space, and we know it in other settings as well, that there are a lot of programs out there that aren't aligned to the same data requirements. And the extent to which the feds are driving that, we really want consistency and where it's state by state, we'd like to encourage the states to talk to each other about can they figure out commonality or can the feds start convening the right stuff to get people to focus on that and get alignment.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

Larry, I would not – the all provider, I think part of the real challenge here – its Don – is really the fact this is a very heterogeneous group of providers.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

And somehow I think, and maybe whether you use the word all provider or something or maybe you just say provider-specific and setting-specific needs, but somewhere in there I think there should be at least – since these are our principles, right?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine**

There should be recognition that this is a very heterogeneous group of providers, because I think – it seems like half of our conversation over the last several meetings has been the setting or provider-specific twists to the proposed regs. So I would call that out, because I think people sort of forget how many different professions, if you will, are touched by this behavioral health policy.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yup. Good point, I like adding that. Um – and so in addition to minimum burden, we're going to add a bullet that there are no broad incentive programs. I'm going to take silence as agreement. Let's look very –

**M**

I agree.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Go ahead.

**John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**

This is John Derr, I agree.

**Carl Dvorak – Chief Operating Officer – EPIC Systems Corporation**

Yeah, this is Carl, I agree as well.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

This is Mike and I agree.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

There was some language in the other provider study report to Congress on something to the effect that the amount, duration and scope of available incentives is not sufficient –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

– to support EHR adoption among these ineligible.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So maybe the no broad incentives really should pick up some of that language about insufficient incentives for broad adoption.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Yeah.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay. Someone else going to jump in? So let's quickly eyeball the slides so you guys know they are there and we'll pick up from there after we talk about the input from the Quality Measures Workgroup. So, next slide. So this was trying to get at that all providers subset intersections, and based on what I'm hearing, maybe this is irrelevant and we should drop it. Any thoughts from you guys?

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University, College of Medicine**

I think it's hel – its Don – I think this is helpful to as we think about this, for people who are maybe not clinically in this space.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right. Okay. I'm happy, I like the graphic and I'm an old fan of Venn diagrams.

**John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**

Yeah, and this is John Derr. And it shows us all working together.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay. The right message, thanks, we'll keep it. Next slide. So we had hoped to get through what's on the right panel – on the left panel today, which we're clearly not going to, but this is pulling forward the specific slides that are going to follow, with a focus on transitions of care – oh, I thought we had a different sequence guys. I thought reconciliation was lower down, privacy and security, enhanced privacy and security, which are the things that Maureen was talking about, and then a whole bunch of other things. Next slide.

And then some broad groupings. So this is the one to noodle on, if you wake up at 3 in the morning thinking about this stuff, this was taking that notion of all providers and saying, we really want to highlight transitions of care, privacy and security. And I purposely put in here the enhancements to privacy and security, because it ripples to everybody, it's not just a change for behavioral health. And we've heard about some setting-specific things and then the bottom blue box, I don't know what the right heading should be because I think in here we had two different logics, one logic was around how central is this to the broad provider types and the second one was, what priority do we think it has? So some of it talks to them as providers and some of it talked to our discussions on priorities. So, I leave –

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

So Larry, on this slide when you're talking about all providers, are you talking about all these ineligible providers that we've been talking about or all providers including eligibles?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yes.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

The latter?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yes both.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

And then if that's the case, then I think – so for example, advanced – well, I guess that's the problem. It's like you have the Venn diagram notion –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

– you miss it on this slide because advanced care planning, medication related, labs and imaging, blah, blah, blah, you'll have some – I guess this sho – there'll be some overlap to the all provider category.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right. That's what I'm saying, having listened through the conversation around all providers, maybe that's not the right dimension to emphasize here?

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

It might be, you might want to just have two boxes and just group them differently, because I think what's more important or prioritized for long-term post-acute care isn't necessarily the same – the list wouldn't be structured the same way for behavioral health.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right. And again, the all provider pieces, these are going to build on existing modules, so where there's an existing module, which is what's all in the blue box, it is inherently an all provider module, and anyone could use that module and the EPs and EHs have to use it.

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration**

And this is Maureen. I might add to the behavioral health specific setting, consent management.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, that's a good addition – specific requirements there.

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Larry, I just want to have a time check again.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

We're at 18 after, thanks. Okay, I can see this is going to take some real thinking, so thank you. Let's jump to the slide that start – it's the very last slide, right, that's the summary, go ahead, let's jump there. Okay, Helen, take it away.

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Wonderful. Thanks so much guys. So actually its remarkable how much of this conversation I've been listening to for the last 15 minutes, that really does resonate quite clearly what a lot of the recommendations that the Quality Measures Workgroup made to the Policy Committee that are now going forward in a transmittal letter to CMS. So just at a very high level, there was a very – a great interest in thinking broadly in terms of a measurement framework that would impact both health and healthcare, patient-centered value and of course, those would logically include behavioral health and some non-eligible providers like long-term care.

We specifically came up with a set of what we called key measure dependencies. Again very logical from the discussion you've just had, about what would need to happen to actually get this set of – these set of more innovative and hopefully meaningful measures out there for MU3, would depend on, of course, having – at least starting down that path of interoperable systems, or at least a subset of key data. Data sharing across providers, some ability to get at population health tools, the ability to build on multiple data sources including, for example, hybrid measures that might pull in claims data for cost data, for example, as well as getting data from other providers and having measures and data that would be accessible across all providers. And ultimately, being able to consistently capture those variables that we would need for stratification. So those are the measure dependencies we know we all need to work on to make that real.

In terms of some of the key domains, several of them highly related, of course, to the National Quality Strategy, not too surprisingly, strong emphasis on continuing to build measures in the patient safety space. And in particular, trying to think about areas where we might be able to get at some key domains like falls prevention, health associated infections and even EHR safety as an example. For each of these we laid out example measures as well as what the HIT infrastructure needs may be, which I think might be particularly relevant for this group.

We also as a second domain looked at the area of population health and equity, and beginning to understand how the infrastructure would allow us to get towards some of those disparities – stratification. The third domain was about efficient use of resources, and in this case, in particular, the ability to get at appropriateness measures and efficient use of facilities and very much interested in understanding how information around costs, duplicate testing, for example, could be brought in to a domain like that.

Fourth domain around patient and family engagement, looking at patient health outcomes, experiences, self-management and in this, in particular trying to understand how the voice of the patient, patient portals, mobile devices and other patient-generated health data could be brought forward for use in quality measures. Fifth domain heavily related around functional status and well-being and similar infrastructure needs there. Care coordination continues to be a very, very large gap for all of us, I think, and that would clearly require the ability to look longitudinally across patients and transitions across settings broadly.

Just a – lastly, we did come up with some criteria that we recommended to the Policy Committee of how you would select measures potentially going forward. The first was you really wanted to make sure that there be preference for ECQMs that leverage the data from HIT systems. This notion we've talked about for several years around HIT sensitivity, that those systems themselves can help improve the quality of care. The second, I think is particularly important given the topics you guys were just discussing, was that the idea that the measure should enable a patient-focused, patient-centered view of longitudinal care. And this would logically go across EPs and EHs, but actually across non-behavioral health providers like behavioral health and the long-term post-acute care community.

The third was the ability to support health risk assessment and outcomes. The fourth again linking back to something you just said, was the preference for reporting once across programs that could aggregate data reporting, so MSSP, whatever the federal program might be, have the ability to report it once. The fifth is that the measurement should be beneficial and meaningful to multiple stakeholders such that the benefits would outweigh the burden and hopefully also, in particular, useful for consumers, purchasers and other end-users. Sixth was the idea that they would promote shared responsibility, that the measure would require that collaboration or interoperability across settings to get at longitudinality. The seventh was it would actually promote efficiency and the eighth was that the measures could ultimately be used for population health level reporting.

We did have a final recommendation around the idea of CMS and ONC considering an innovation pathway where – optional pathway where people might be able to submit some of the more innovative measures and get credit for using innovative or locally developed ECQMs in place of meeting some of the requirements currently. And I think I'll just stop there, in the interest of time, and see if you have any specific questions.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

So Dr. Burstin, this is Jennie Harvell. And so you mentioned one of the big gaps was on care coordination.

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Um hmm.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

I'm wondering, did you make any recommendations for how to address that gap or how to approach that topic?

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

There were some recommendations specifically about thinking about how data would increasingly need to be available across providers. We did not get into specific measure recommendations, although that's something up for discussion, actually we have a call with the Chairs of the committee actually at 12:30, to begin talking through whether we need to take this to a level specifically more – with greater specificity. But for example, some example measures that were put forward was percent of patients with contact without patient services within seven days, effective partnering with community resources. So again, I think the theme we kept hearing over and over again was that to get at all of these, a rate-limiting step for so many of these important measures we'd like to have for the next stage of Meaningful Use will require the ability to share that information across providers and across settings.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So if we thought we were challenged on standards, you have a much tougher road to hoe.

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Oh, we're all in this together. But it is really complex, I mean I think, actually, my work at the NQF, for example, we're now in our second project on care coordination in the last several years and we continue to put out calls for new measures, and there are very, very precious few new ones. I think mainly because the data infrastructure has still been really challenging.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I guess I'm not so overly process and short circuit this, I guess what I'm hearing is, this is a great place where we would turf this to you guys.

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

And give me a little bit more information, turf what exactly.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, we've been looking at certification criteria that would apply to long-term acute care and behavioral health settings.

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And quality measures came up as one of the things to look at –

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– and I think that rather than add one more group that's talking specifics of quality measures, especially because we didn't really get there. That this would be a place to say, we have a group doing quality measures and the extent to which they look at improving care coordination, that's the key thing that we've taken on as one of our guiding principles, because it's important.

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Okay.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And that it should be, and maybe this is the all provider piece I'm trying to get at on that original principle slide.

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Um hmm.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

It should be neutral in its framing that to whatever extent possible, to whether or not someone is eligible for HITECH incentives or not –

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Um hmm.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– that the measure should be defined to look broadly at all providers and not be niched measures that we have gobs of today, but we need to start thinking about measures that really work well across all settings.

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Yeah.

**John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**

Larry, this is John Derr. I agree, we have enough people with their fingers in the quality measurement pool and I think Helen's group is the one that's really got to harmonize and pull all those together, otherwise we'll never get to the answers of quality measures.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Okay.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

This is Jennie again and so I'm wondering Dr. Burstin, you mentioned I guess gaps in the data infrastructure and I'm wondering if in terms of the long-term post-acute care and behavioral health provider sectors, being ready to step up and support of be able to provide the data necessary for different quality measures. And maybe it's not possible even to answer this question at this point without the specification of the measures. But, I'm wondering if there are key parts of the data infrastructure that you think we should pay attention to as this group goes forward in making recommendations regarding certifi – EHR certification criteria that if implemented, might provide some key infrastructure support, I guess?

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Right, no, I think that's a great question and obviously, we say we want to get information from these other providers, but that may not be currently doable. I think that would actually be a question I'd love to have us bring back to our workgroup, I think we're meeting next week, and see if we can get to some answers there. Just top of mind, it would certainly, I would think, be really important to at least make sure that the – that at the key transition points, there is an infrastructure to support the availability of information to get at follow up, to get at hospitalization, rehospitalization, information flow, in particular. But again, I think Lauren's on the phone taking notes, so we can certainly bring that back to the committee as well.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Thank you.

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

Sure.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Any other final comments for Helen before we go to public comment?

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

All right, excellent.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Thank you Helen, this was great.

**Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum**

All right. Okay, take care. Bye.

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

You ready Larry?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I'm ready.

**Public Comment**

**Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology**

Operator, can you please open the lines?

**Ashley Griffin – Management Assistant – Altarum Institute**

If you are on the phone and would like to make a public comment, please press \*1 at this time. If you are listening via your computer speakers, you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue. We have no public comments at this time.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I'd like to thank the workgroup members for their time today. I'd like to remind everybody we have a call on Tuesday, March 4 from 12:30 to 2:30 and we will have to be very focused because that's our last go-round before we meet with the Policy Committee on the 11<sup>th</sup>. Thanks again for everybody's time.